Arizona Health Care Cost Containment System

Arizona Department of Health Services

Children's Rehabilitative Services

Report for Contract Year 2007

External Quality Review

Annual Report

Submitted by:
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EXECUTIVE SUMMARY

The Children's Rehabilitative Services (CRS) program is administered through the Arizona Department of Health Services (ADHS), Division of Public Health Services/Office for Children with Special Health Care Needs (DPHS/OCSHN). Children's Rehabilitative Services Administration (CRSA) provides a limited scope of services to children who have specific medical, disabling, or potentially disabling conditions which have the potential for functional improvement. The most common conditions are cerebral palsy, congenital circulatory problems, and congenital musculoskeletal deformities. Arizona Health Care Cost Containment System (AHCCCS) eligible CRS children are concurrently enrolled in an AHCCCS Acute Care or Arizona Long Term Care System (ALTCS) Contractor for their primary health care needs.

The purpose of this External Quality Review (EQR) Annual Report is to evaluate CRSA's compliance with requirements of prepaid inpatient health plans (PIHPs) described in the Balanced Budget Act of 1997 (BBA). This review is limited to three areas of CRSA activity during Contract Year 2007. They are CRSA's performance measures, its two performance improvement projects (PIPs), and an Analysis and Evaluation (A&E) of its compliance with federal and state regulations.

CRS recipients are included in the AHCCCS Acute Care or ALTCS population from which samples are drawn for Acute Care or ALTCS plan performance measures. Therefore, the standard performance measurement process established for Acute Care or ALTCS Contractors is not applicable to CRSA. As a result, AHCCCS created three performance measures that are unique to the CRS program and are reflective of the services provided by CRSA. Due to the unique nature of these performance measures, there are no national standards or benchmarks that can be used for comparison. The performance measures are listed as follows.

- Preliminary determination of medical eligibility
- Timeliness of initial evaluation
- First appointment with a CRS specialty provider

This is the first year that data have been available to report on performance measures for CRS. AHCCCS calculations indicate that CRSA is minimally meeting the standard for preliminary determination of eligibility, and is below the minimum standard for timeliness of initial evaluation and first appointment with a CRS specialty provider. In response to these findings, CRSA has developed an extensive corrective action plan to improve performance on all three measures.

For Contract Year Ending (CYE) 2007, CRSA has demonstrated significant progress in its ability to implement meaningful performance improvement projects. CRSA currently has two performance improvement projects. They are Transition Services for Youth and Non-Utilization among Children's Rehabilitative Services Members.

The Transition Services for Youth PIP is in its third year, which is an intervention year. Baseline and one remeasurement have been completed. During the validation process for the first remeasurement some discrepancies were identified by HCE QualityQuest (QQ), the External Quality Review Organization. However, the overall results and conclusions are the same as those reported by CRSA. The number of children with a documented transition plan in the medical record initiated prior to their 15th birthday is far below the desired level. The analysis of the results by CRSA in its annual report to AHCCCS is complete and thoughtful, as is the barrier analysis and corrective action plan. A second remeasurement is planned for CYE 2008.

The PIP on Non-Utilization among Children's Rehabilitative Services Members has completed a baseline measurement activity, produced a baseline report, and is implementing interventions this year. This represents a significant step forward compared to PIPs that CRSA has attempted in the past.

AHCCCS has a written Quality Assessment and Performance Improvement Strategy to comply with the BBA requirement. On a regularly scheduled basis, AHCCCS monitors and evaluates access to care; organizational structure and operations; clinical and non-clinical quality measures; and performance improvement outcomes. This monitoring is accomplished through an ongoing report and document review, regular meetings with CRSA staff, and an annual onsite operational and financial review (OFR).

Data for three years of Operational and Financial reviews are included in this report. Overall, significant progress has been made during CYE 2007. Full compliance has gone from 26% to 55.9% and noncompliance has dropped from 51% to 16.5% over the course of the contract year. The most significant improvement occurred in the areas of Grievance/Appeals, Quality Management, Recipient Services, and Medical Management.

CRSA has been operating under a Notice to Cure from AHCCCS since June 2005. At the time of this review, the Notice to Cure had been in effect for 21 months. The Notice to Cure was issued as a result of major quality of care and quality management deficiencies identified by AHCCCS. Many of these deficiencies had documentation to indicate improvements were made during the last contract year, but too late in the contract year to have a significant impact on the outcome of the last review. Therefore it was expected that the findings of the CYE 2007 OFR would demonstrate significant progress in many areas, which was demonstrated.

Despite the major achievements made this year, opportunities for improvement continue to exist. CRSA's performance measures and its compliance with federal and state regulations should continue to improve. However, CRSA is meeting the AHCCCS and BBA standards for demonstratable improvement under the Transition PIP.

I. BACKGROUND

Arizona's Medicaid program, known as AHCCCS, was formed in 1982 and was the first Medicaid program in the United States to be granted a 1115 Waiver. This waiver refers to a certain provision of the Social Security Act that outlines specific requirements for Medicaid. The waiver allows Arizona to operate a demonstration project using a managed care model for the delivery of health care services.

Prior to the implementation of the AHCCCS program, CRS was known in Arizona as the Society for Crippled Children. This society was founded in 1929 as a private charitable organization caring for poor children suffering from the effects of poliomyelitis and other conditions, such as club foot.

In 1935 the Social Security Act provided federal money to be used for the operation of this program. Today the program is known as Children's Rehabilitative Services. The CRS program is currently administered through the Arizona Department of Health Services (ADHS), Division of Public Health Services/Office for Children with Special Health Care Needs (DPHS/OCSHN). In Arizona the Medicaid program and the CRS program are managed by two independent state agencies.

Under the Balanced Budget Act (BBA) of 1997, CRS is classified as a prepaid inpatient health plan (PIHP) and is accountable for evaluating, measuring, and ultimately improving the quality of care delivered to its members.

It is important to note that all Medicaid eligible children are assigned to an AHCCCS Acute Care or ALTCS Contractor for their acute, long term, and preventative health care needs. However, for those specifically defined conditions covered by CRS, services are provided through a network of four CRS regional Contractors (clinics).

The regional Contractors are located in Flagstaff, Phoenix, Tucson and Yuma. These entities are responsible for establishing a network of providers, therapists, and other appropriate facilities and services to meet the care needs related to the covered conditions of eligible CRS recipients within their contracted geographic service area (GSA).

When a child is identified with a CRS covered condition, the child is referred by the Acute Care or ALTCS Contractor to CRSA for evaluation. If the evaluation verifies that a child's condition qualifies for CRS coverage, the child must receive all care for that condition from a CRS clinic and its contracted provider network. Medicaid children with a CRS qualifying condition are essentially enrolled in two health care systems.

Each Medicaid eligible child in CRS is included in the Acute Care or ALTCS Contractor's performance improvement projects and performance measures. Most of the standard PIPs and performance measures mandated by AHCCCS for the Acute Care/ALTCS Contractors have been based on traditional Healthcare Effectiveness Data and Information Set (HEDIS®) measures, such as immunization rates and well-child visits. These services are not provided by CRSA.

As a result, CRS is in a unique position. Prior to 2005, specific PIPS and performance measures for CRSA were not contractually required. This changed with the contact renewal on July 1, 2005. AHCCCS has identified specific performance measures for CRSA and identified the methodology for a specific performance improvement project that began in CYE 2006.

CRS members are included in the AHCCCS Quality Strategy and are considered a special needs population. The scope of the Quality Strategy as outlined by AHCCCS includes the following features.[1]

- Aspects of care including: coordination, accessibility, availability, level of care, continuity, appropriateness, timeliness, and clinical effectiveness of care and services covered by AHCCCS.
- Aspects of Contractor performance relating to access to care, quality of care and service, including, but not limited to: disease management, preventative care, health promotion, patient care planning, network contracting (includes professional and paraprofessional workforce development) and credentialing, and grievance systems.
- Professional and institutional care in any setting, including inpatient and outpatient, in-home, and alternative settings.
- Professional and paraprofessional providers and any other delegated or subcontracted provider types such as providers of transportation or durable medical equipment.
- Aspects of Contractors' internal administrative processes that are related to service and quality of care. This includes member services, provider relations, confidential handling of medical records and information, case management services, utilization review activities, preventive health services, health education, information systems and quality improvement.

[1]*State of Arizona Health Care Cost Containment System, Quality Assessment and Performance Improvement Strategy, December 2007, p. 12.*

II. DESCRIPTION OF EXTERNAL QUALITY REVIEW ACTIVITIES

The BBA of 1997 requires states to review health plan compliance with federal and state law regarding managed care systems every three years. An annual External Quality Review (EQR) report also is required. AHCCCS contracted with HCE QualityQuest (QQ) to perform this EQR Annual Report for CRS for contract year 2007. This report is limited to a review of performance measures, performance improvement projects, and compliance with federal and state regulations. AHCCCS prepared binders that included relevant reports and documents for QQ to analyze and evaluate. A complete list of what was included in the binders has been included in the Appendix.

The Organizational Assessment and Structure Performance review was based on the information provided in the Annual Operational and Financial Review for CYE 2007 conducted by AHCCCS on March 12-16, 2007. The findings in that report were analyzed and compared to findings from the previous years. The data was graphed and displayed by QQ. A description of the process used by AHCCCS is included in the Organizational Assessment and Structure Performance section of this report.

The performance measurement review of CRSA for CYE 2007 was completed using information provided to QQ in the binders provided by AHCCCS. This is the first year that data has been available to report on performance measures for CRSA and methodological issues are still being refined. Data validation of performance measures will be included in future External Quality Review activity.

Two Performance Improvement Projects were reviewed by QQ for CYE 2007. The first is titled Improving Pediatric to Adult Transition Services for Youth. Transition planning allows young people to optimize their ability to function as adults. CRSA requires its regional Contractors to initiate transition services at 14 years of age. This project was designed to determine the percentage of children who have documented transition plans initiated and to develop interventions aimed at eliminating the barriers to providing these services when identified.

An independent data validation was performed on a sample of thirty-five medical records provided by CRSA as part of the review of the Improving Pediatric to Adult Transition Services for Youth PIP. The process used by QQ is described in the Performance Improvement Project section later in this report.

The second Performance Improvement Project reviewed is titled Non-Utilization Among Children's Rehabilitative Services Members. Its purpose is to identify opportunities to promote proper utilization of needed services and discharge members who should no longer be enrolled in CRS.

AHCCCS uses the results of this EQR report to assist in the identification of strengths and opportunities for improvement. According to AHCCCS, EQR reports are a driving force in assessing the effectiveness of the Quality Assessment and Performance Improvement Strategy.

III. STATE QUALITY INITIATIVES

In compliance with federal regulations, AHCCCS has a written Quality Assessment and Performance Improvement Strategy designed to ensure that services provided to members meet or exceed established standards for access to care, clinical quality of care, and quality of service. This document highlights the quality initiatives implemented by the state to support Contractor efforts to improve the quality of care and service provided to members. Some of the major accomplishments of Arizona to date include the following examples.[1]

- **Performance Measures** – AHCCCS was among the first to utilize HEDIS® measures or HEDIS®-like measures for Medicaid managed care. In 2001, AHCCCS implemented a system of Minimum Performance Standards, Goals and Benchmarks for each performance measure, which Managed Care Contractors must meet, or be subject to corrective actions and/or sanctions. The Minimum Performance Standard (MPS) and Goal for each measure are based on an objective methodology designed to "narrow the gap" between the current statewide average and a Benchmark, a longer-range goal specified in contract that is usually based on a comparable "Healthy People" 2010 Goal for improvement.

  This system has helped achieve a high level of overall performance in several areas of preventive health, as measured by HEDIS® specifications. For example, the overall average of AHCCCS Contractors for annual dental visits provided to Medicaid enrollees younger than 21 years of age is in the top 10 percent of Medicaid health plans nationally. Other areas in which the AHCCCS program outperforms the national average for Medicaid health plans are some measures of childhood immunizations and well-child visits in the first 15 months of life. AHCCCS continues to explore new ways to drive further improvements in performance and raise expectations for Contractor performance (e.g., by increasing Minimum Performance Standards, to ensure that members receive preventive health care services).

- **Performance Improvement Projects** – The Agency has a well-developed process for identifying and conducting projects to improve performance in key areas of clinical care and non-clinical services that affect health outcomes and enrollee satisfaction. In 2002, AHCCCS implemented a Performance Improvement Project (PIP) to improve the health of members with diabetes by ensuring they had a specific type of blood test at least once a year and that their blood-glucose levels were considered to be controlled. The project focused on improving blood-glucose testing and laboratory levels for members enrolled with Acute Care and ALTCS Contractors. The PIP resulted in overall rates of testing and control that exceeded the national Medicaid average, with the rate of "poor control" of blood-glucose levels ranking among the best-performing Medicaid health plans in the nation.

- **Spouse as Paid Caregiver** – To continue to expand the Home and Community Based Services (HCBS) network within ALTCS and allow more choice for ALTCS members, AHCCCS requested and received a waiver from CMS to allow members to select their spouse to be their paid caregiver. Although this may not be a viable option for many members, there are those member/family situations (e.g., working spouse needed to quit his/her job to provide the seven-day-a-week, 24-hour per day intermittent care) that will be able to benefit from this option. The Spouse as Paid Caregiver Policy became effective in October, 2007.

- **Self-Directed Attendant Care** – Consumers and advocates have been requesting that AHCCCS develop a Self-Directed Attendant Care Program so that members may have more control of and better manage their needs. Led by an ALTCS Program Contractor, the development work teams have included members, providers, advocates and AHCCCS Contractors. Self-Directed Attendant Care will encourage members to make decisions that will more likely result in positive outcomes.

- **Collaborative Oversight of Nursing Facilities** – AHCCCS has worked with ALTCS Contractors to coordinate the monitoring and oversight of nursing facilities in the largest Arizona County. The initiative also includes Health Services Advisory Group, the CMS QIO and the Arizona Department of Health Services (ADHS). This process has reduced the burden on nursing facilities, by reducing the number of AHCCCS Contractors scheduling and conducting quality management reviews allowing them more time for member care and quality improvement activities. In addition, this process has freed time for Contractor resources to evaluate and improve monitoring and oversight of the home and community based program, much of which has far less state licensure oversight.

- **AHCCCS Data Decision Support System** – In 2005, the Agency implemented a "data warehouse," known as the AHCCCS Data Decision Support System (ADDS), which provides a more timely and flexible way to monitor performance measure data, as well as analyze utilization data by type of treatment or provider, and run specialized queries. When ADDS was developed, the Agency incorporated HEDIS® measures, including many that had not been previously used, into the data warehouse. There are now more than 100 separate measures, ranging from Adolescent Well Care Visits to Use of Imaging Studies for Low Back Pain that can be selected to monitor and improve quality. Results for measures can be analyzed by individual Contractor, geographic area, race/ethnicity, and specific beneficiary categories. This allows the Agency and its Contractors to target efforts where improvement is needed and likely to be most beneficial.

- **AHCCCS E-Health Initiative –** Arizona recognizes that early adoption of a statewide electronic-health (e-health) information infrastructure will improve the quality and reduce the cost of health care in Arizona. As an awardee of CMS's Medicaid Transformation Grant program, by 2009 AHCCCS will deploy a statewide health information exchange (HIE) utility, electronic health record (EHR) central repository, and a Web-based system to access and maintain the EHR. The project is being achieved in cooperation with the public-private coalition, Arizona Health-e Connection, through the AHCCCS Health Information Exchange and Electronic Health Record Utility.

  Through this electronic utility, all Medicaid providers will have instant access to beneficiaries' health records by electronic connection at the point of service. The HER features available through this utility will include storage and retrieval of personal health information in a common standardized format by authorized users. Implementing this HIE utility will transform the AHCCCS Medicaid program and the member care process. Providing timely member health information at the point of service will improve the quality, efficiency and effectiveness of Arizona's Medicaid program. Real time health information access will result in improved member care through reduction of medical errors, reduction of redundant testing and procedures, better coordination of care for members with chronic diseases, increased preventive interventions, reduction in the inappropriate use of the emergency room, and lower administrative costs.

AHCCCS has several projects under development as well as under consideration pending baseline reporting of targeted information. The following are key initiatives and interventions under development.[2]

- **AHCCCS E-Health Initiative**

  In addition to the information provided above, the initiative will promote the following activities.

  - Facilitate the connection of 35% of AHCCCS providers, who will be actively sharing electronic health information through the HIE utility by the end of 2009. Connect 60% of AHCCCS providers by the end of 2010. By the end of 2011, more than 90% of the providers will be included.
  - Improve quality of care oversight and quality transparency through the provision of timely performance information.
  - Improve care coordination for members (or beneficiaries) with chronic diseases, and foster better coordination between behavioral and physical health services.
  - Enhance opportunities for better self-management of chronic illnesses by beneficiaries and their families through access to personal health information and online wellness materials.

➢ Pay-for-Performance

- AHCCCS participates in a Center for Health Care Strategies (CHCS) grant that focuses on developing pay-for-performance programs in Medicaid.
- Pay-for-performance programs under consideration focus on diabetes, prenatal care, childhood immunizations, and care provided in nursing homes.
- Funding for the Pay-for-Performance programs has been requested from the Arizona legislature.

➢ Return on Investment

- AHCCCS is involved in a CHCS grant regarding return on investment. AHCCCS has linked this project to the CHCS pay-for-performance grant.
- AHCCCS will be utilizing a CHCS developed tool to calculate what the return on investment would be for implementing interventions to improve quality of care outcomes.
- Outcomes from this project will be utilized to evaluate the value of investing in pay-for-performance programs related to other initiatives.

➢ Increased Contractual Performance Standards

- Under consideration pending baseline reporting of targeted information are revisions to the contractual Performance Standards that would better align minimum performance levels and benchmarks with the most current HEDIS® means and percentiles for Medicaid managed care organizations, as reported by the National Committee for Quality Assurance. This mechanism is designed to ensure overall measures of quality meet or exceed national averages for Medicaid enrollees.

[1]*State of Arizona Health Care Cost Containment System, Quality Assessment and Performance Improvement Strategy, December 2007, p. 14-16.*
[2]*State of Arizona Health Care Cost Containment System, Quality Assessment and Performance Improvement Strategy, December 2007, p. 32-33.*

IV. BEST AND EMERGING PRACTICES FOR IMPROVING QUALITY OF CARE AND SERVICES

AHCCCS regularly shares best practices with, and provides technical assistance to, its Contractors and encourages them to share evidence-based best practices with each other and their providers.[1] This is accomplished through sharing successful interventions during AHCCCS Contractor Quality Management, Maternal and Child Health, Medical Management, Medical Director, and Administrator meetings. CRSA is included in these activities.

Standard published performance measures and benchmarks do not apply to the special needs population. Quality of care and service measures unique to the special needs population are not yet readily available either locally or nationally.

[1]*State of Arizona Health Care Cost Containment System, Quality Assessment and Performance Improvement Strategy, December 2007, p. 7.*

V. ORGANIZATIONAL ASSESSMENT AND STRUCTURE PERFORMANCE

A. Objective

The BBA requires Medicaid agencies that contract with Medicaid Managed Care Organizations (MCOs) "to develop a state quality assessment and improvement strategy that is consistent with standards established by the Department of Health and Human Services (DHHS)."[1] AHCCCS has a written Quality Assessment and Performance Improvement Strategy to comply with the BBA requirement. The document was developed with input from AHCCCS members, the public, and other stakeholders. It is reviewed annually and/or when a significant change is proposed and implemented. AHCCCS' Quality Strategy was reviewed and updated based on content expectations found in CMS' Quality Strategy Tool Kit released in 2006. "The Quality Strategy is designed to ensure that services provided to members meet or exceed established standards for access to care, clinical quality of care, and quality of service." [2]

AHCCCS reports Quality Strategy activities, findings, and actions to AHCCCS members, other stakeholders, Contractors, the governor, legislators, and the Centers for Medicare & Medicaid Services (CMS).[3] BBA provisions apply to PIHPs, prepaid ambulatory health plans (PAHPs), and primary care case management programs (PCCMs). CRS is classified as a PIHP. In recognition of this, the AHCCCS' contract with CRSA has been modified over time to comply with these requirements. Federal requirements are broadly defined under the following categories.

- Enrollee Rights and Protections
- Quality Assessment and Performance Improvement
- Access Standards
- Structure and Operations Standards
- Measurement and Improvement Standards
- Grievance System

B. Description of Data and Information Collection Methodology

In its oversight of CRSA, AHCCCS uses a combination of methods designed to complement each other and provide as complete a picture as possible of CRSA operations. On a regularly scheduled basis AHCCCS monitors and evaluates CRSA compliance with access to care, organizational structure and operations, clinical and non-clinical quality measurements, and performance improvement outcomes through the following activities.

- Annual onsite Operational and Financial Reviews
- Review and analysis of periodic reports
- Review and analysis of program specific performance indicators and Performance Improvement Projects

The contract between AHCCCS and CRSA contains a detailed list of periodic reporting requirements. These reports are reviewed by AHCCCS on an ongoing basis by the department responsible for the content of the reports. In addition to required reports, the contract also requires CRSA to submit the following documents to AHCCCS for review or approval.

- A CRSA Policy Manual, with copies of final policies submitted to AHCCCS at least ten business days prior to implementation
- Physician Incentive Plan Disclosures
- All subcontracts for the provision of AHCCCS covered services
- Requests for Proposals to provide AHCCCS covered services
- Legislative Proposals and Initiatives

Upon receipt by AHCCCS, the documents listed above are forwarded to the specific department within AHCCCS that has the expertise needed to analyze the content of the document. Where applicable, checklists have been developed for staff to use in the review process, ensuring that all required federal and state requirements are addressed. AHCCCS responds in writing, and either approves the document or requests revisions.

In addition to reviewing the deliverables described above, AHCCCS conducts an onsite review annually. The onsite review provides them the opportunity to review and validate CRSA compliance with contract requirements. AHCCCS refers to these onsite reviews as Operational and Financial Reviews (OFRs). The process used for these reviews has been refined over several years. A uniform tool is used to review each Contractor, although the tool used for CRSA has been modified to reflect its unique scope of service. The format of the review follows nationally recognized processes and is modeled after NCQA guidelines.

The actual onsite activities include document review, staff interviews, and observations of operations. This process is consistent with the protocol developed by CMS that includes the following recommended activities.

- Planning for the review
- Obtaining background information
- Document review
- Conducting interviews
- Collecting accessory information
- Reporting results

For CYE 2007, AHCCCS identified the following as the primary objectives for the CRSA Operational and Financial Review.

- Determine if CRSA satisfactorily meets AHCCCS' requirements as specified in the CYE 2007 contract, AHCCCS policies and the Arizona Administrative Code (AAC).
- Increase knowledge of CRSA's operational and financial procedures.
- Provide technical assistance and identify areas where improvements can be made as well as identifying areas of noteworthy performance and accomplishments.
- Review progress in implementing recommendations made during prior Operational and Financial Reviews.
- Determine if CRSA is in compliance with its own policies and to evaluate the effectiveness of those policies and procedures.
- Perform oversight of CRSA as required by the Centers for Medicare & Medicaid Services in accordance with the AHCCCS 1115 waiver.
- Provide the information to an External Quality Review Organization (EQRO) for its use as described in 42 CFR Part 438.364.

Upon completion of the Operational and Financial Review, key program areas are scored according to the following scale.

Full Compliance	90-100% agreement with standard(s)
Substantial Compliance	75-89% agreement with standard(s)
Partial Compliance	50-74% agreement with standard(s)
Noncompliance	0-49% agreement with standard(s)

A written report that includes findings and recommendations is then produced. Recommendations are made based on the following definitions.

- "CRSA must" – This indicates a critical noncompliance area that must be corrected as soon as possible to be in compliance with the AHCCCS contract.
- "CRSA should" – This indicates a noncompliance area that must be corrected to be in compliance with the AHCCCS contract, but it is not critical to the everyday operation of CRSA.
- "CRSA should consider" – This is a suggestion by the review team to improve operations of CRSA, although it is not directly related to contract compliance.

In addition, AHCCCS regularly obtains feedback from the Acute Care/ALTCS Contractors on CRSA issues. The Acute Care/ALTCS Contractors are likely to be the first to know if CRS recipients or providers are having difficulty navigating the CRS system. They report these problems to AHCCCS on an ongoing basis.

A monthly meeting with Medical Directors from the state's contracted health plans provides a forum to keep this dialogue open. The CRSA Medical Director attends these meetings. In combination, these oversight activities provide AHCCCS with an accurate assessment of CRSA compliance with state and federal requirements.

C. Findings from CYE 2007 Compliance Review

A summary of the findings from the CRSA OFR for CYE 2007 is displayed in Table 1 and Chart 1. Overall, 152 standards were reviewed and scored. An additional three standards were reviewed for information only, but were not included in the scoring process or in the findings displayed in Table 1 and Chart 1.

Table 1
Summary of Children's Rehabilitative Services
CY 2007 Operational and Financial Review Findings

Program Area	Number of Standards Reviewed	Compliance Rating for Standard			
		Full	Substantial	Partial	Noncompliant
Claims Systems	19	5 26.3%	4 21.1%	4 21.1%	6 31.6%
Cultural Competence	10	3 30%	1 10%	3 30%	3 30%
Delivery Systems	18	12 66.6%	1 5.6%	0 0%	5 27.8%
Encounters	11	9 81.8%	1 9.1%	1 9.1%	0 0%
General Administration	9	5 55.6%	1 11.1%	2 22.2%	1 11.1%
Corporate Compliance	12	8 66.7%	2 16.7%	0 0%	2 16.7%
Grievance and Appeals	20	11 55%	5 25%	3 15%	1 5%
Medical Management	8	3 37.5%	3 37.5%	1 12.5%	1 12.5%
Recipient Services	12	8 66.7%	2 16.7%	0 0%	2 16.7%
Delegated Agreements	6	4 66.7%	0 0%	0 0%	2 33.3%
Quality Management	19	9 47.4%	5 26.3%	3 15.8%	2 10.5%
Third Party Liability	8	8 100%	0 0%	0 0%	0 0%
Overall	152	85 55.9%	25 16.5%	17 11.2%	25 16.5%

As can be read from the overall findings displayed in Table 1, 55.9% of the standards reviewed were in full compliance, 16.5% were rated as substantially compliant, 11.2% partially compliant and 16.5% were rated as noncompliant.

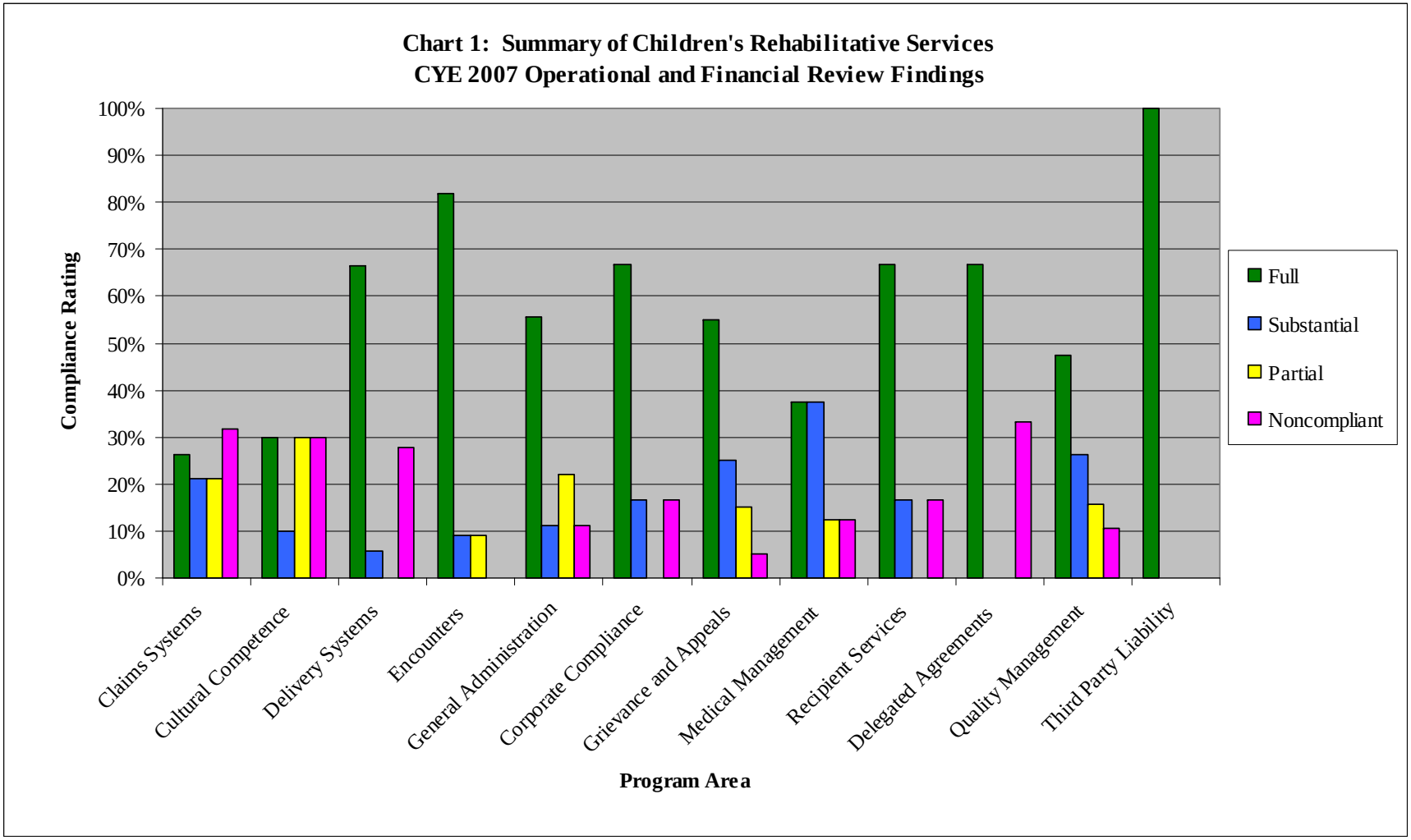


Chart 1: Summary of Children's Rehabilitative Services
CYE 2007 Operational and Financial Review Findings
Compliance Rating
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Full
Substantial
Partial
Noncompliant
Claims Systems
Cultural Competence
Delivery Systems
Encounters
General Administration
Corporate Compliance
Grievance and Appeals
Medical Management
Recipient Services
Delegated Agreements
Quality Management
Third Party Liability
Program Area

The program areas with the highest percent of findings at full compliance are listed.

- Third Party Liability 100.0%
- Encounters 81.8%
- Corporate Compliance 66.7%
- Recipient Services 66.7%
- Delegated Agreements 66.7%
- Delivery Systems 66.7%

A broader measure of compliance may be appreciated by combining full compliance with substantial compliance and ranking those areas with a combined score of at least 75%.

When this is done, the program areas with the strongest performance are as follows.

- Third Party Liability 100.0%
- Encounters 90.9%
- Corporate Compliance 83.4%
- Recipient Services 83.4%
- Authorization & Denial/Grievance System 80.0%

The program areas with the poorest performance as measured by the level of noncompliance are as follows.

- Delegated Agreements 33.3%
- Claims Systems 31.6%
- Cultural Competence/Limited English Proficiency 30.0%

D. Assessment of Strengths and Weaknesses

In the area of third party liability, eight standards were reviewed and all were found to be fully compliant. AHCCCS made no comments and had no suggestions for improvement in this area. Clearly this is an area of strength for CRSA. CRSA policies and procedures for third party liability appear to be highly effective.

Eleven encounter standards were reviewed. Reported findings are based on a statistical analysis of submitted encounter data. The methodology applied in the analysis is described in the review document used by AHCCCS.

Of the eleven encounter standards reviewed, 90.9% were rated at full or substantial compliance. None were found to be noncompliant and only one standard was rated partially compliant. The partially compliant standard related to professional claim submissions of which almost two-thirds of them were from the same provider.

Twelve standards were reviewed for corporate compliance. Of these, 83.4% of the standards reviewed were rated at full or substantial compliance. Only two (16.7%) were rated as noncompliant and none were rated partially compliant. The areas of noncompliance can be improved by CRSA tracking and trending cases referred to AHCCCS for appropriateness (e.g., suspected Fraud and Abuse), identifying training needs, and by reviewing the timeliness and effectiveness of the compliance program.

Twelve standards were reviewed for recipient services. Of these, 83.4% were rated at full or substantial compliance. Only two standards were rated as noncompliant. The areas of noncompliance centered on staff training and monitoring in general but especially in the area of ensuring that dignity and privacy are protected and that the recipient is treated with respect. In addition, CRSA needs to notify AHCCCS when material changes in the network occur. Otherwise CRSA was able to demonstrate that recipients are provided with all the required information needed to participate in the CRS program.

Twenty standards were reviewed in the authorization and denial/grievance system. This represents the most standards reviewed in any one area during CYE 2007. The reason for the intense focus on this area was because of problems identified in the past.

Beginning in November of 2006, AHCCCS required CRSA to submit all of its Notice of Action letters for review. At that time, CRSA did not ensure that the four regional Contractors were using a standardized Notice of Action letter and that the reasons for denials or reductions of service were explained in easily understood language. AHCCCS provided technical guidance and oversight until the Notice of Action letters were brought into compliance. The findings of the OFR demonstrate that CRSA is now in compliance with these activities.

Eighty percent of the standards reviewed for authorization and denial/grievance system were rated at full or substantial compliance. Only one standard was rated as noncompliant and three (15%) were rated as partially compliant. AHCCCS identified that the Notice of Extension and Notice of Decision letters are in need of standardization and a process for CRSA to monitor compliance must be implemented.

Six standards were reviewed for delegated agreements. Four standards (66.7%) were fully compliant and two standards (33.3%) were noncompliant. CRSA does have a formal review process in place and has developed a tentative schedule for these reviews. However, the reviews have not yet been completed. Documented completion of this process should lead to full compliance in future reviews.

The claims subsystem included a review of 19 standards. CRSA's performance in this area is fairly evenly split across the compliance continuum. It fully complies with keeping AHCCCS informed of recoupment activity, claims aging and inventory tracking, and the adjudication of 90% of all clean claims within 30 days of receipt and 99% of clean claims within 60 days of receipt.

Additional work is needed to track, trend, and to ensure that interest penalties are applied when applicable. In addition, the acceptance of electronic claims and staff training and auditing need further development.

Ten standards were reviewed for cultural competence/limited English proficiency. In 40% of the standards reviewed, full or substantial compliance was achieved.

CRSA has an approved cultural and linguistic program that complies with contract requirements. It uses parent action councils to assist in the development of all recipient materials. This is especially useful since the cultural needs of the CRS population are driven primarily by the needs and limitations presented by the recipients' disabilities, in addition to language and ethnicity.

Despite these accomplishments, significant work remains to be done in the area of cultural competence/limited English proficiency. There is no documented staff and provider training program and no way to assess the competence of the staff once trained. CRSA needs to devote additional resources to this area in order to improve compliance.

Eighteen standards were reviewed to assess delivery systems. Seventy-two percent (72%) of the standards reviewed were rated at full or substantial compliance. CRSA fully complies with the standards requiring that subcontractors and providers are notified in writing by way of policy and contract of all AHCCCS requirements, especially appointment standards and communication with the recipient's Acute Care/ALTCS provider.

Nine general administrative standards were reviewed. Of these, 66.7% were rated at full or substantial compliance. Only one was rated noncompliant and two were rated partially compliant. CRSA must develop, implement and monitor policies and procedures to ensure that all contracts and fee schedules are loaded to the claims payment system accurately and timely. In addition, CRSA needs to finalize and implement a standardized New Employee Orientation program.

Eight standards were reviewed for medical management. Seventy-five percent (75%) of the standards were rated as full or substantially compliant. One standard was rated noncompliant and one standard was rated partially compliant. CRSA needs to devote additional resources to the areas of inter-rater reliability testing and the post payment review process to further improve compliance in the area of medical management.

Nineteen standards were reviewed for quality management. Of these, 73.7% were rated as full or substantially compliant and 26.3% were rated as partially or noncompliant.

The process in place for PIPs, staffing levels, and medical record standards are in full compliance. Completion of the annual administrative review of the regional Contractors and documentation of delegated reviews will increase overall compliance in quality management.

In addition, CRSA needs to more clearly articulate the role of the Medical Director to include signing medical management policies, chairing the credentialing committee, and the peer review process. These additions are easily accomplished without the expenditure of many resources.

E. Comparison to the CYE 2005 and 2006 Compliance Review

Comparisons to the CYE 2005 and CYE 2006 reviews are displayed in Table 2 and Charts 2.1 to 2.8. Only those program areas that were reviewed in all years were included in the analysis and presentation.

The Utilization Management program was renamed to the Medical Management program in CYE 2006 and some standards were moved from one program area to another. These changes are reflected in the tables displayed.

Overall, significant progress has been achieved in CYE 2007. Full compliance has risen from 26% to 55.9% and noncompliance has dropped from 51% to 16.5% in CYE 2007. The most significant improvement occurred in the areas of grievance/appeals, quality management, recipient services, and medical management.

The significant progress in grievance and appeals occurred following AHCCCS intervention. CRSA did not ensure that the Notices of Action sent by the four regional Contractors were compliant with federal regulations and in easily understood language. CRSA was required to submit all of its Notice of Action Letters to AHCCCS for review until compliance was consistently demonstrated.

Positive progress also was demonstrated in the area of quality management. In CYE 2006, none of the QM standards were rated as fully compliant. During the CYE 2007 OFR, nearly 50% of the standards received a rating of full compliance. Further progress should be demonstrated once the annual administrative reviews of the regional Contractors are completed by CRSA and the findings are documented.

During CYE 2008, CRSA should further define the role of its Medical Director to include signing medical management policies, chairing the credentialing committee, and managing the peer review process. Continued progress should be evident at the next compliance review.

Recipient Services showed significant improvement over CYE 2006 with full compliance improving from 28.6% to 66.7%. CRS members are now receiving all required material needed to access services and participate in the CRS program. Standardization and oversight of the regional clinic materials have greatly improved performance in this area.

CRSA made significant progress in the area of medical management during CYE 2007. Full compliance has risen from 0% in CYE 2006 to 37.5% in CYE 2007.

In CYE 2007, CRSA was able to demonstrate ongoing monitoring and evaluation of service utilization. Reports are regularly presented at the Medical Management (MM) and Utilization

Management (UM) committee meetings and the minutes of those meetings reflect a commitment to the management and oversight of this area.

Also, progress has been made in the area of concurrent review which includes the medical necessity of inpatient stays. CRSA was fully compliant with this standard.

F. Conclusion

As is evident from the data, CRSA made significant progress in compliance in CYE 2007. Full compliance improved from 26% to 55.9% and noncompliance dropped from 51% to 16.5%.

Despite the achievements and successes of the past year, more progress is still needed. Continuation of the work already in progress and delineated in the corrective action plan will ensure further improvements in compliance during the coming year.

The completion of delegated activity reviews scheduled with the four regional Contractors, implementation of the New Employee Orientation program, and more clearly articulating the role of the Medical Director to include all of the required quality management activities, are three areas where additional improvement can be achieved in the coming year. Completion of the work already in progress will continue to improve compliance with quality management requirements.

Some long-term challenges remain in the area of CRS' medical management information systems. Progress in this area will require extensive planning and resource allocation but has the potential to greatly impact the overall ability of CRSA to successfully manage the program in the future.

Table 2

Selected Comparison of Children's Rehabilitative Services Administration
CYE 2005, 2006, and 2007 Operational and Financial Review Findings

Program Area	Number of Standards Reviewed			Compliance Rating for Standard											
				Full			Substantial			Partial			Noncompliant		
	CYE 2005	CYE 2006	CYE 2007	CYE 2005	CYE 2006	CYE 2007	CYE 2005	CYE 2006	CYE 2007	CYE 2005	CYE 2006	CYE 2007	CYE 2005	CYE 2006	CYE 2007
Delivery System	21*	11	18	38.1%	36.4%	66.6%	9.5%	45.5%	5.6%	9.5%	0.0%	0.0%	42.9%	18.1%	27.8%
Recipient Services	12*	7	12	16.7%	28.6%	66.7%	0.0%	14.3%	16.7%	8.3%	14.3%	0.0%	75.0%	42.8%	16.7%
Grievance and Appeals	20	20	20	45.0%	5.0%	55.0%	45.0%	5.0%	25.0%	0.0%	10.0%	15.0%	10.0%	80.0%	5.0%
Utilization/Medical Mgmt.	19	12	8	5.3%	0.0%	37.5%	5.3%	0.0%	37.5%	15.8%	8.3%	12.5%	73.7%	91.7%	12.5%
Quality Management	17*	11	19	29.4%	0.0%	47.4%	5.9%	0.0%	26.3%	29.4%	9.0%	15.8%	35.3%	91.0%	10.5%
Cultural Competency	9	4	10	0.0%	0.0%	30.0%	0.0%	0.0%	10.0%	55.5%	0.0%	30.0%	44.4%	100.0%	30.0%
General Administration	14	6	9	21.4%	66.6%	55.6%	7.1%	16.7%	11.1%	28.5%	16.7%	22.2%	42.8%	0.0%	11.1%
Overall	159	96	152	29.6%	26.0%	55.9%	9.4%	10.4%	16.5%	16.4%	12.5%	11.2%	44.7%	51.0%	16.5%
* excludes standards reviewed for "Information Only" and "Not Applicable"															

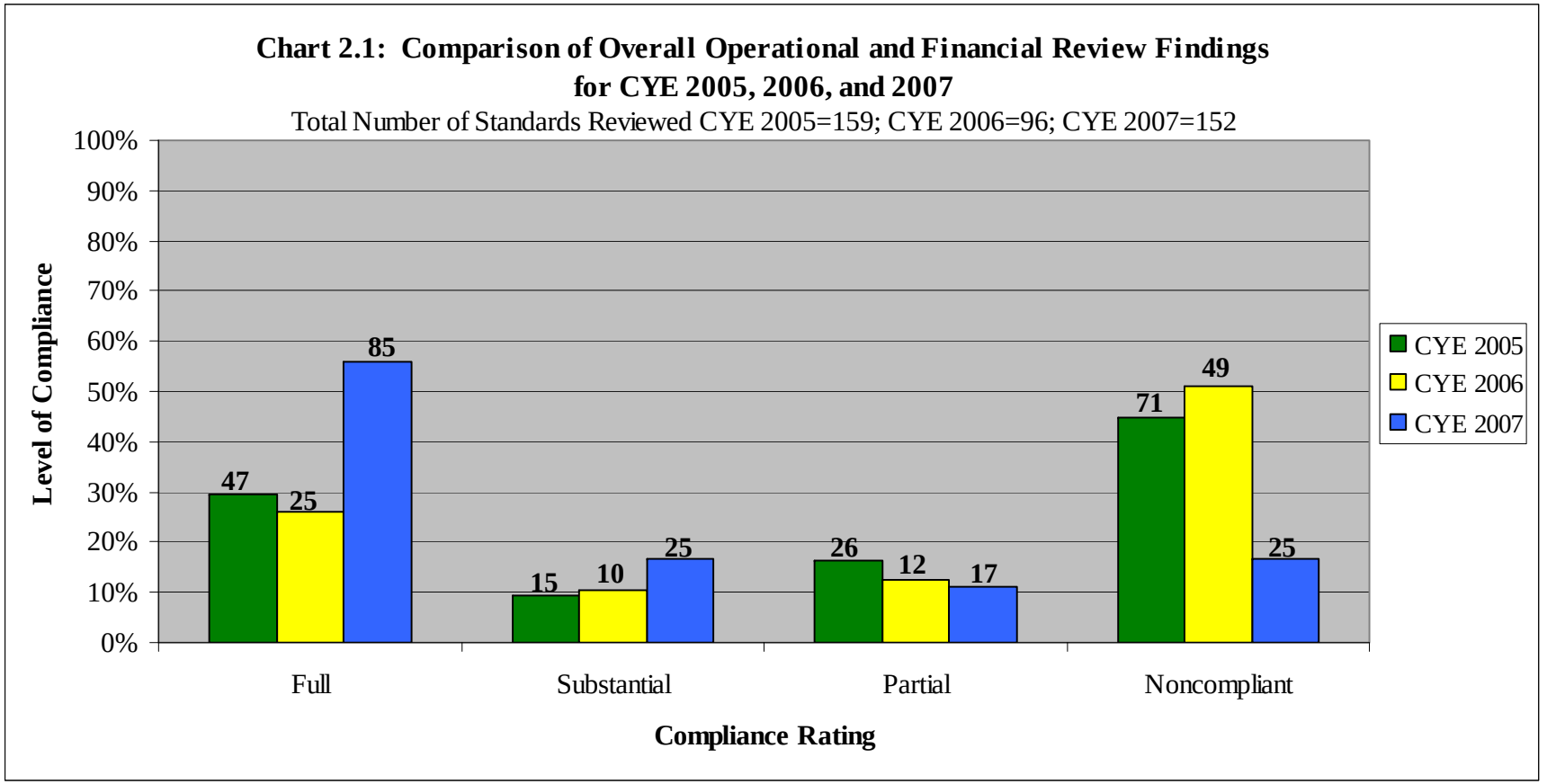


Chart 2.1: Comparison of Overall Operational and Financial Review Findings for CYE 2005, 2006, and 2007
Total Number of Standards Reviewed CYE 2005=159; CYE 2006=96; CYE 2007=152
Level of Compliance
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
47
25
85
15
10
25
26
12
17
71
49
25
Full
Substantial
Partial
Noncompliant
Compliance Rating
CYE 2005
CYE 2006
CYE 2007

Chart 2.2: Delivery System
Comparison of CYE 2005, 2006, and 2007
Total Number of Standards Reviewed CYE 2005=21; CYE 2006=11; CYE 2007=18

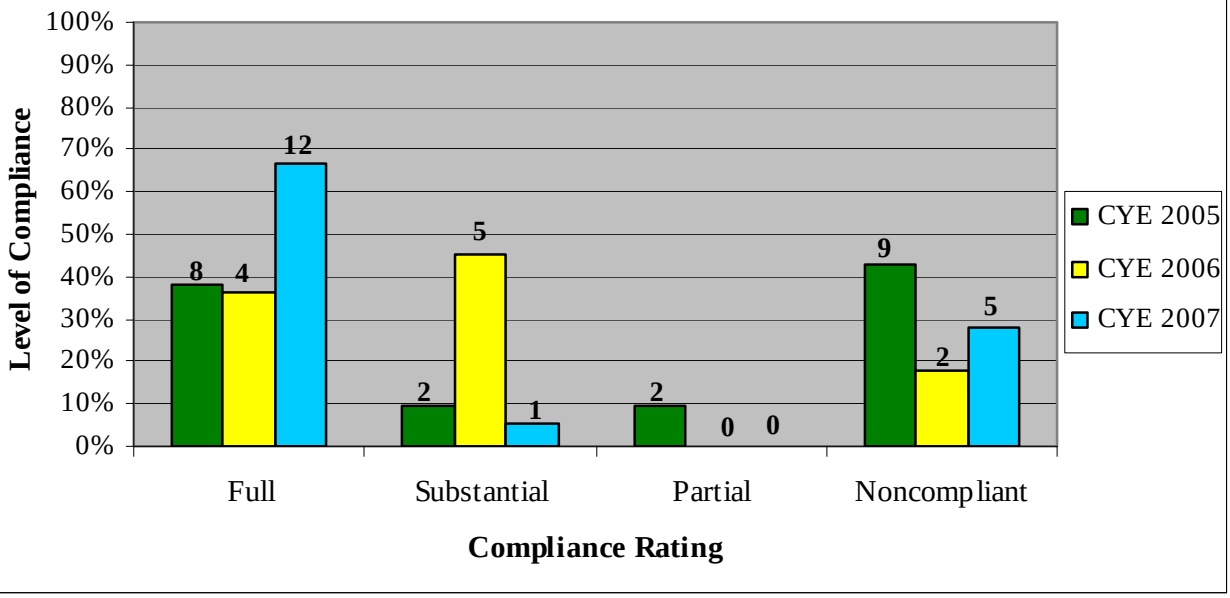


Chart 2.3: Recipient Services
Comparison of CYE 2005, 2006, and 2007
Total Number of Standards Reviewed CYE 2005=12; CYE 2006=7; CYE 2007= 12

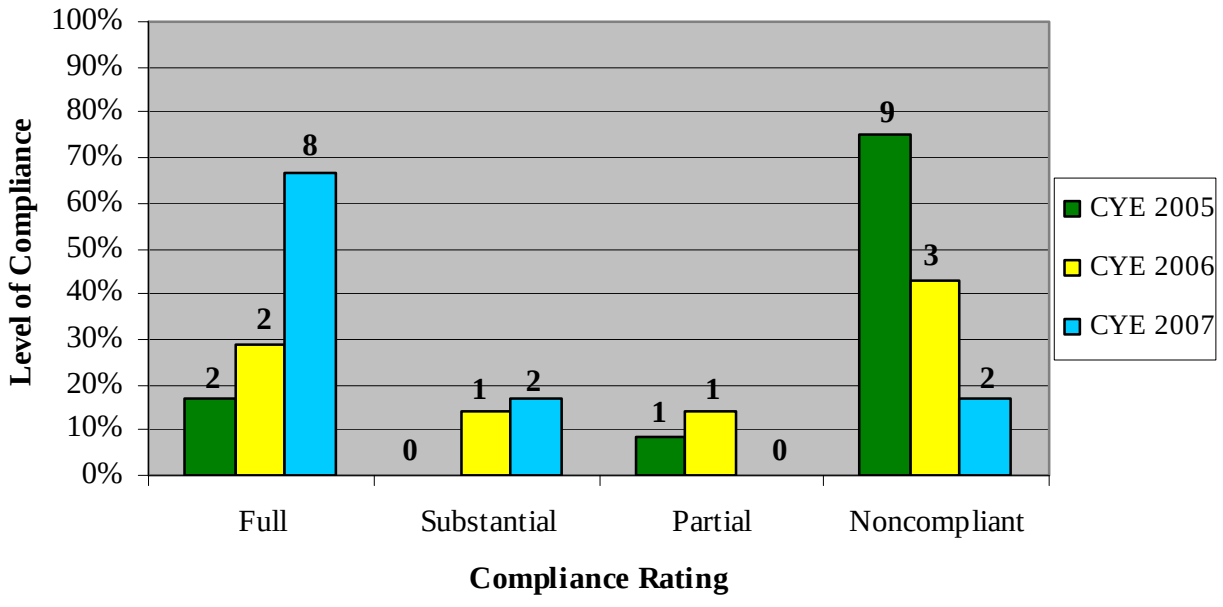


Chart 2.4: Grievance and Appeals
Comparison of CYE 2005, 2006, and 2007
Total Number of Standards Reviewed CYE 2005=20; CYE 2006=20; CYE 2007=20

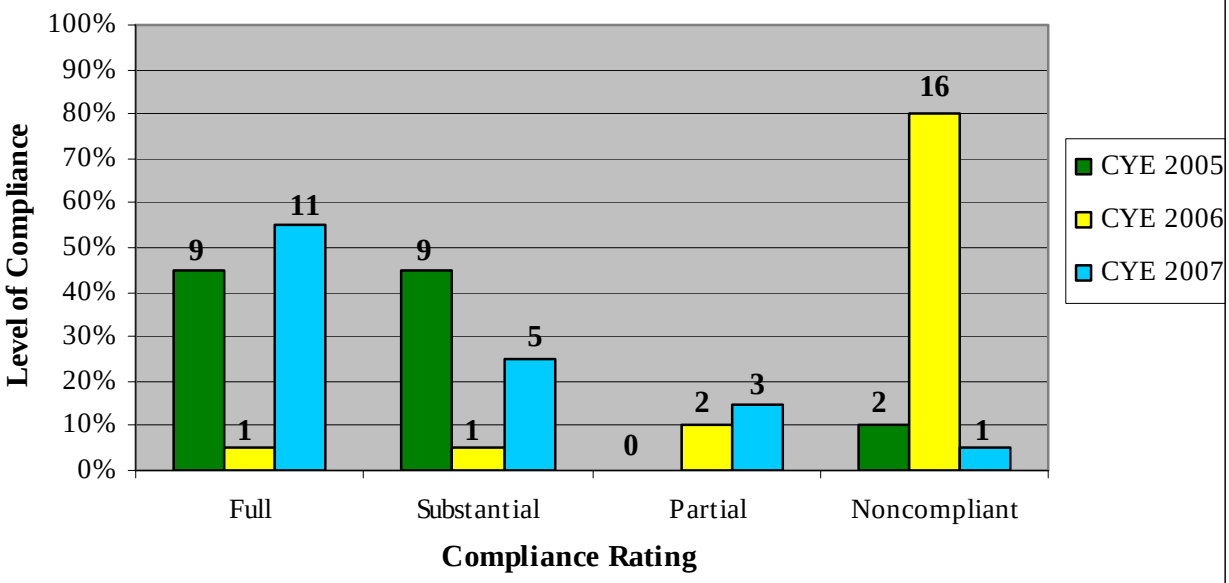
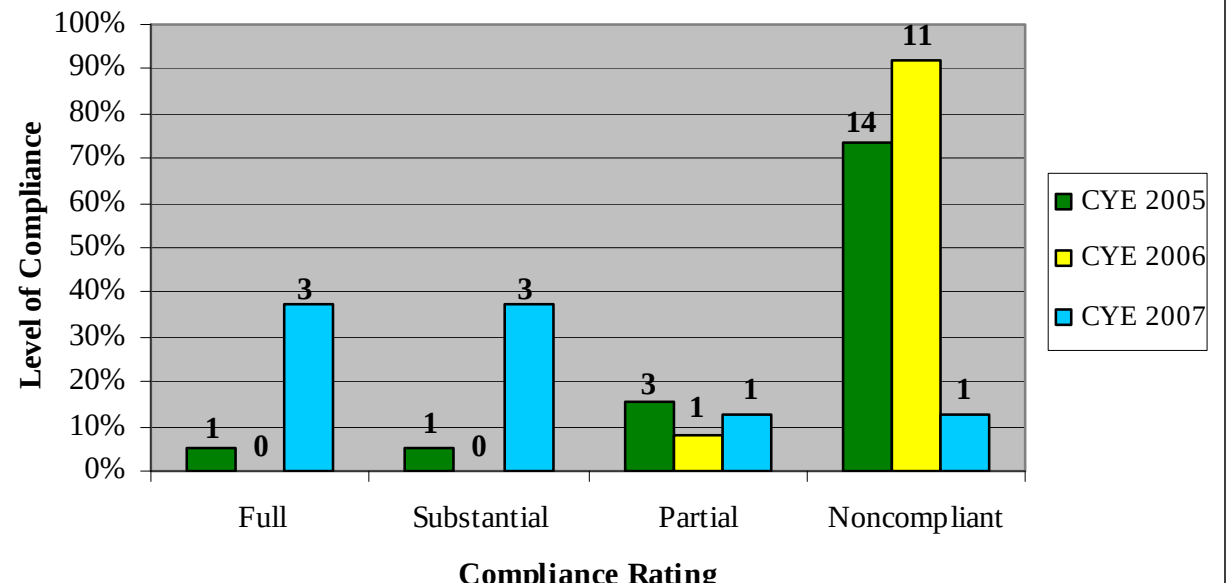


Chart 2.5: Utilization/Medical Management
Comparison of CYE 2005, 2006, and 2007
Total Number of Standards Reviewed CYE 2005= 19; CYE 2006=12; CYE 2007=8



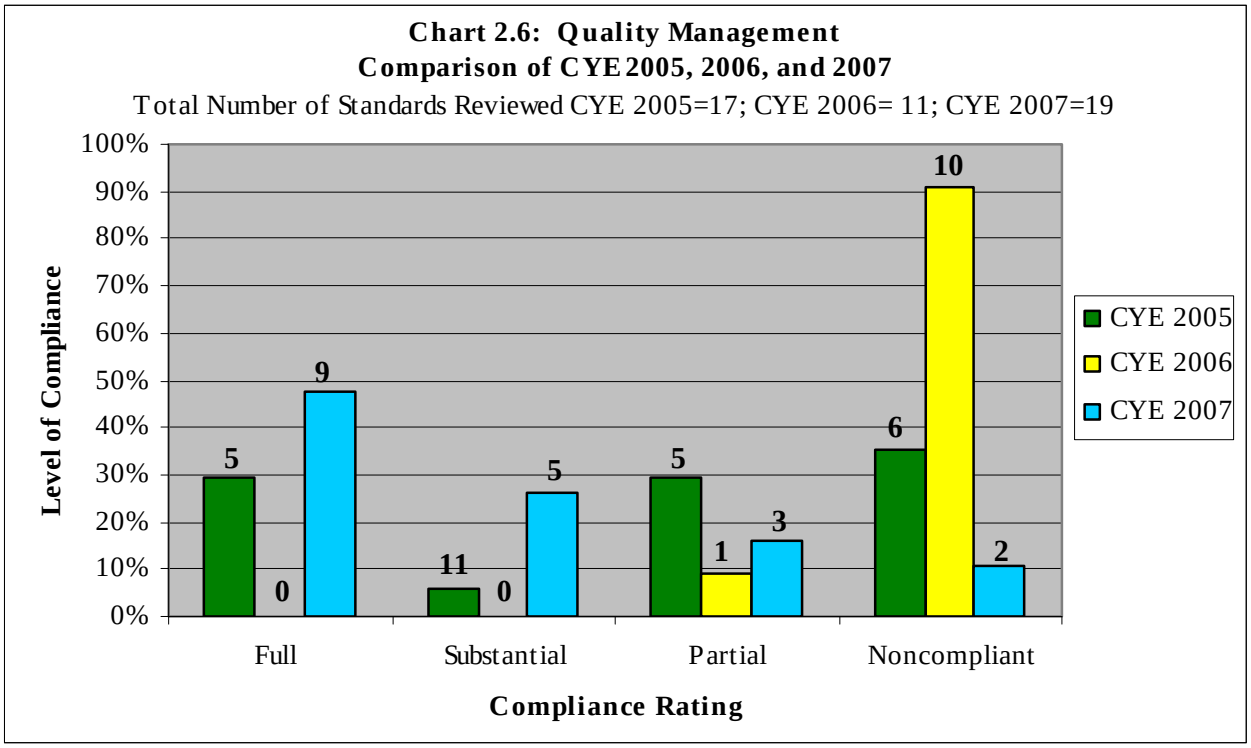


Chart 2.6: Quality Management
Comparison of CYE 2005, 2006, and 2007
Total Number of Standards Reviewed CYE 2005=17; CYE 2006= 11; CYE 2007=19
Level of Compliance
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
5
0
9
11
0
5
5
1
3
6
10
2
Full
Substantial
Partial
Noncompliant
Compliance Rating
CYE 2005
CYE 2006
CYE 2007

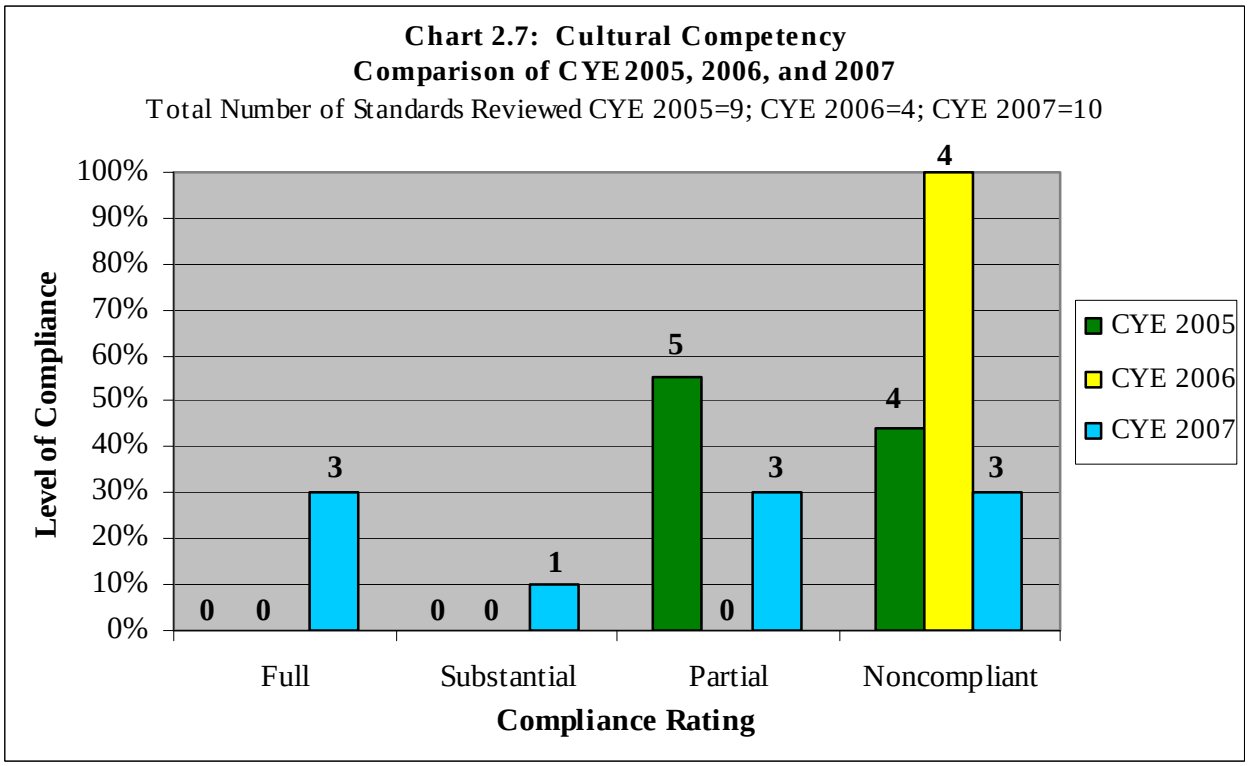
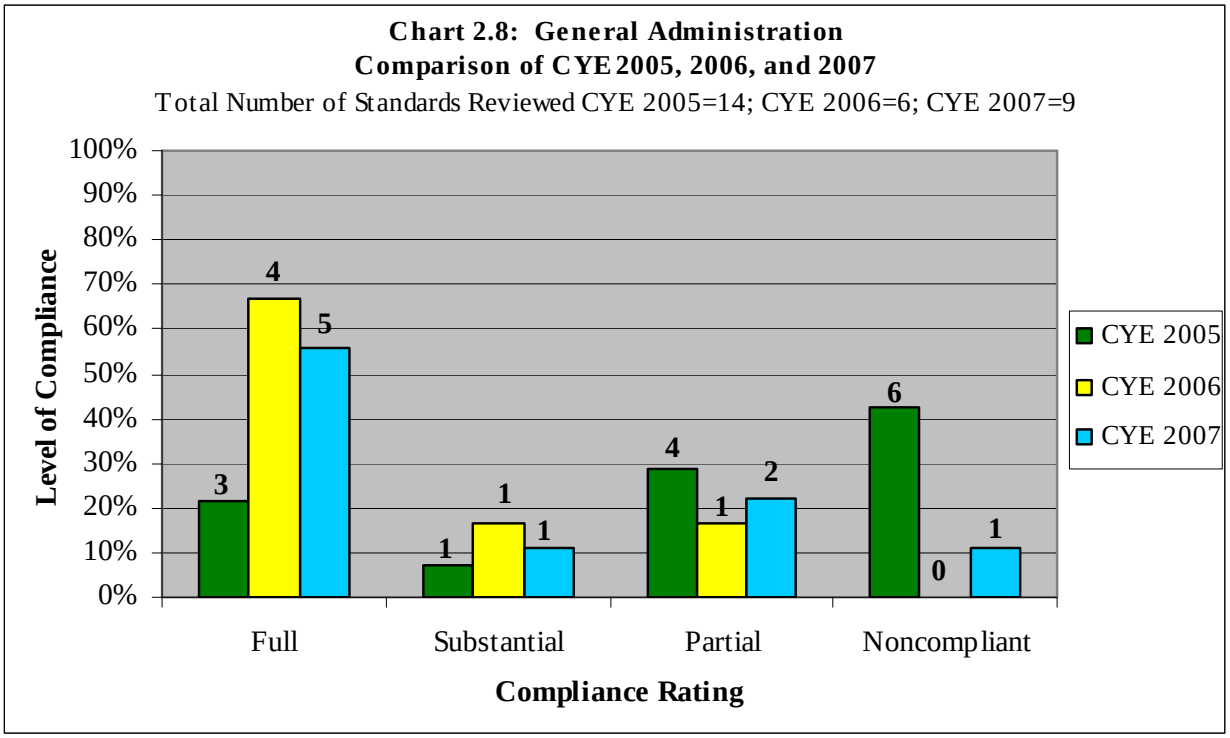


Chart 2.7: Cultural Competency
Comparison of CYE 2005, 2006, and 2007
Total Number of Standards Reviewed CYE 2005=9; CYE 2006=4; CYE 2007=10
Level of Compliance
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
0
0
3
0
0
1
5
0
3
4
4
3
Full
Substantial
Partial
Noncompliant
Compliance Rating
CYE 2005
CYE 2006
CYE 2007



[1]*Department of Health and Human Services, Centers for Medicare & Medicaid Services, Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPS): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR 400, 430, et al., Final Protocol, Version 1.0, February 11, 2003, p. 1.*
[2]*State of Arizona Health Care Cost Containment System, Quality Assessment and Performance Improvement Strategy, December 2007, p. 1.*
[3]*State of Arizona Health Care Cost Containment System, Quality Assessment and Performance Improvement Strategy, December 2007, p. 2.*

VI. PERFORMANCE MEASUREMENT PERFORMANCE

As described in its Quality Assessment and Performance Improvement Strategy, AHCCCS recognizes the need for identifying, tracking, and trending performance measures as a component of assessing the overall quality of care delivered to its members. It recognizes for these measures to be reliable and valid, the methodology used must be sound and based on nationally recognized standards.

AHCCCS uses the Healthcare Effectiveness Data and Information Set (HEDIS®) to measure performance in its acute care plans. HEDIS was developed by the National Committee for Quality Assurance (NCQA) and is considered the national standard for measuring and reporting health plan performance.

In addition to identifying the performance measures, AHCCCS identifies a minimum performance standard, a goal, and a benchmark for each measure. The benchmarks are based on the goals for health promotion and disease prevention developed by the U.S. Department of Health and Human Services as part of its Healthy People 2010 publication.

Medicaid eligible CRS recipients are dually enrolled in AHCCCS and primary health care needs are provided by an Acute Care or ALTCS Contractor. CRSA is responsible for services directly related to specific conditions covered by CRS such as spina bifida or cerebral palsy.

CRS recipients are included in the Acute Care or ALTCS Contractor population from which samples are drawn for the Contractor's performance measures. For example, when measuring immunization rates for two year old children, all of the two year olds are eligible to be included in the sample, even those receiving specialized services through CRSA.

Because CRS recipients are concurrently enrolled in Acute Care or ALTCS, the performance measurement process established for Acute Care or ALTCS Contractors is not appropriate for CRSA. In the past, CRSA was exempt from reporting on standard performance measures. However, beginning July 1, 2005, AHCCCS included in its contract renewal with CRSA three performance measures that CRSA must report on annually.

These measures are unique to the CRS program and are reflective of the services provided by CRSA. Due to the unique nature of these performance measures, there are no national standards or benchmarks that can be used for comparison. AHCCCS has delineated the methodology to be used and established minimum performance standards and a goal for each measure. Table 4 identifies these requirements.

Table 4
Children's Rehabilitative Services Performance Measures
Minimum Performance Standards and Goals

Performance Measure	Minimum Performance Standard	Goal
Preliminary Determination of Medical Eligibility	75%	90%
Timeliness of Initial Evaluation	75%	90%
First Appointment with CRS Specialty Provider	75%	90%

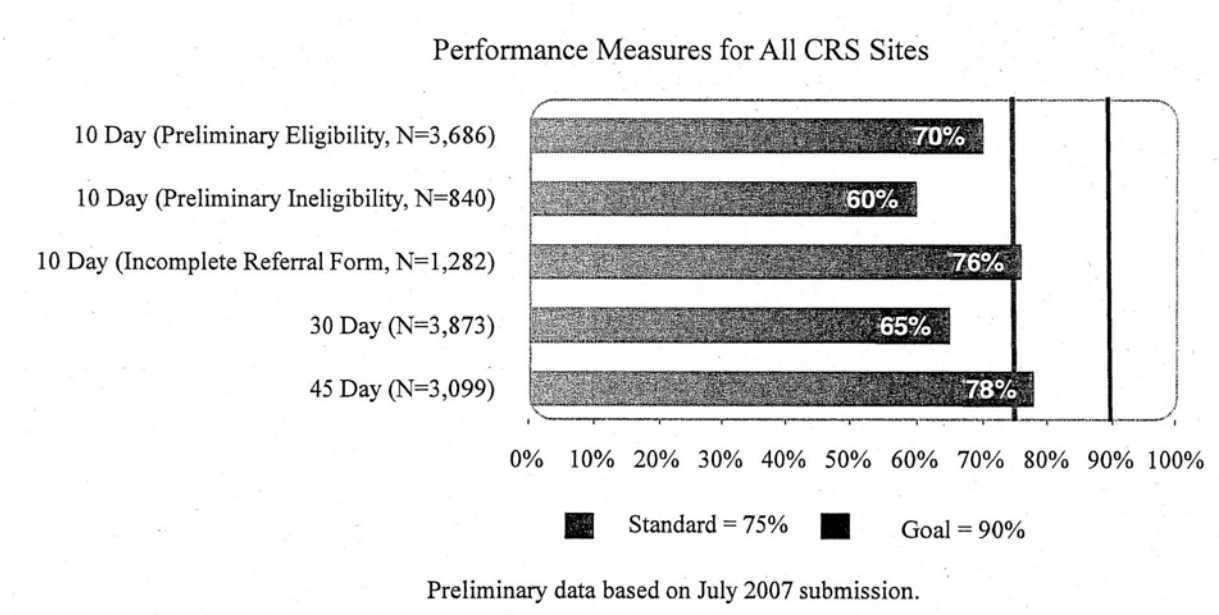
Reporting on these performance measures was to begin with CYE 2006. CRSA did report data for CYE 2006 and AHCCCS was able to calculate rates and complete statistical analysis of the CRSA performance measures. Due to problems with the data provided, AHCCCS choose not to make statistical comparisons between the CYE2006 and CYE 2007 data.

In CYE 2007 many of the problems with the CYE 2006 data were resolved. It is worth noting that CRSA's analysis of the data deviated from AHCCCS methodology, particularly in calculating the first appointment with a CRS specialist. Both CRSA and AHCCCS were able to report on performance measures for CYE 2007.

CRSA Reported Performance Measures

In its Quality Management Evaluation for CYE 2007 CRSA reported the following data on performance measures.

Chart 3



According to this report, CRSA is meeting the minimum standard for a first appointment with a CRS specialty provider within 45 days at 78%. CRSA did not report an aggregate rate for preliminary determination of medical eligibility but did report on the three components. The CRSA report did not provide enough information to verify the calculations or to identify and track how they were done based on the methodology specified in the contract.

AHCCCS Reported Performance Measures

AHCCCS calculated rates for CRSA performance measures based on data submitted by CRSA on October 1, 2007, for the CYE 2007. The findings reported by AHCCCS are identified in Table 5.

Table 5
Children's Rehabilitative Services Performance Measure Rates for CYE 2007

Measure	Denominator	Number of Members Meeting Numerator Criteria	Percent of Members Meeting Numerator Criteria
Preliminary Determination of Eligibility	4,036	3,059	75.79%
Timeliness of Initial Evaluation	3,133	2,003	63.93%
First Appointment with CRS Specialty Provider	2,720	1,622	59.63%

Note: Denominators vary because members not having a preliminary determination of eligibility are not included in denominators for Timeliness of Initial Evaluation and First Appointment with CRS Specialty Provider. In addition, members were not determined eligible for CRS during the initial medical evaluation or did not show for their initial medical evaluation appointment are excluded from the denominator for First Appointment with CRS Specialty Provider.

The data reported by AHCCCS indicates that CRSA is meeting the minimum standard for preliminary determination of eligibility with a rate of 75.79%, and is below the minimum standard for timeliness of initial evaluation and first appointment with a CRS specialty provider.

CRSA's results differ from AHCCCS' results because CRSA made additional changes to the denominator and/or numerator for each measure. These changes were not identified in the Quality Management Evaluation Report and were not consistent with the methodology outlined in the contract. Both reports indicate that additional work is needed by CRSA to improve its performance in at least two measures.

In response to these findings, CRSA has developed an extensive corrective action plan to improve performance on all three measures and to ensure the accuracy of the data submitted by the regional clinics. Performance measurement data are now reported and analyzed at each meeting of the CRS UM/QM Committee.

Additionally, CRSA issued a Notice to Cure to the regional clinics with the lowest performance. The Notice to Cure stipulated that they must show demonstrable and sustained improvement toward meeting the minimum performance standard for all performance measures.

In follow-up reports to AHCCCS on corrective action plan activities, CRSA has reported significant improvements with performance measures. These improvements will be documented in future annual reports. AHCCCS plans to continue working with CRSA on refining the methodology used to measure performance. Changes made to the methodology will be documented in future contracts.

VII. PERFORMANCE IMPROVEMENT PROJECT PERFORMANCE

Performance Improvement Projects (PIPs) are an important component of the overall AHCCCS Quality Assessment and Performance Improvement Strategy. The requirement to design and implement PIPs is included in AHCCCS' contract with CRSA. The guidelines for conducting PIPs are detailed in AHCCCS' Medical Policy Manual (AMPM) in Policy 980, Chapter 900.

AHCCCS' Medical Policy Manual complies with the protocols published by CMS. These protocols state that "The purpose of PIPs is to assess and improve processes, and thereby, outcomes of care. In order for such projects to achieve real improvements in care, and for interested parties to have confidence in the reported improvements, PIPs must be designed, conducted and reported in a methodologically sound manner."[1]

As required in 42 CFR 438.236, PIPs shall include the following components.

- Identify clinical or non-clinical areas for improvement
- Gather baseline data from administrative data and other sources
- Design and implement interventions
- Measure the effectiveness of the intervention
- Maintain and sustain the improvement

PIPs are intended to take four years to complete. AHCCCS requires that a baseline measurement be established at the end of the first year. In year two the emphasis is on intervention. A remeasurement to determine if improvement has been made is conducted in year three. If improvement is demonstrated, the measurement is repeated in the fourth year to document sustained improvement.

AHCCCS requires all Contractors to submit, on an annual basis, a Quality Management (QM) and Evaluation Plan. The QM Plan is the vehicle used to propose new PIPs and provide updates and progress reports on those in progress.

AHCCCS must approve all PIP proposals prior to implementation. The following steps are incorporated into a tool for reviewing PIP proposals.

- Review the selected study topic(s)
- Review the study question(s)
- Review selected study indicator(s)
- Review the identified study population
- Review sampling methods (if sampling was used)
- Review the MCO/PIHP's data collection procedures
- Assess the MCO/PIHP's improvement strategies
- Review data analysis and interpretation of study results
- Assess the likelihood that reported improvement is "real" improvement
- Assess whether the MCO/PIHP has sustained its documented improvement

At the time of this review, CRSA was actively working on two PIPs. The first is titled Improving Pediatric-to-Adult Transition Services and the second is titled Non-Utilization among CRS Members. This report reviews the status of both projects.

Improving Pediatric to Adult Transition Services for Youth

The initial proposal for this project was submitted by CRSA in December, 2004. After several revisions to the methodology, AHCCCS approved the project and incorporated it into the contract with CRSA.

Work on this PIP began in CYE 2005 and a baseline measurement was reported in CYE 2006. Activities for improvement were initiated, and a remeasurement was done in CYE 2007. A summary and analysis of these activities is outlined below.

A. Objectives

The purpose of this PIP is to improve transition services for adolescents approaching adulthood and "aging out" of CRS services. Transition planning allows young people to optimize their ability to function as adults.

CRSA requires its regional Contractors to initiate transition services for recipients at 14 years of age. This project was designed to determine the percentage of adolescents who have documented transition plans initiated and to develop interventions aimed at eliminating the barriers to providing these services when identified.

B. Description of Data Collection Methodology

Two study questions are identified in this PIP proposal.

1. What percent of members within the measurement period have a transition plan initiated and documented in the medical record by their 15th birthday?
2. How do the percentages compare by CRS Contractor site?

The study indicator is identified as the percent of enrolled members with a documented transition plan initiated by their 15th birthday. The study indicator adequately supports the study question. The indicator criterion states the following.

"Documentation must include the date on which a transition plan was initiated and must be in the member's medical record. The planning process may take place via telephone call or by patient encounter in a clinic. Mailing of an information letter or packet without documentation of a subsequent telephone call or encounter to discuss transition is not sufficient documentation of a transition plan. Documentation must specifically reference transition, and must be documented by the 15th birthday."

The population to be included in the study is described as "CRS members enrolled in AHCCCS or KidsCare who turned 15 years of age on or between July 1, 2003 and June 30, 2004 and were continuously enrolled for 12 months prior to and including their 15th birthdays."

The PIP calls for selecting a stratified random sample using a 95% confidence level and a confidence interval of +/-5%. The denominator is defined as "The number of CRS members who turned 15 years of age on or between July 1, 2003 and June 30, 2004, and who were continuously enrolled in CRS for 12 months prior to and including their 15th birthdays, and were concurrently enrolled in AHCCCS." The numerator is defined as "The number of members in the denominator who have a transition plan initiated and documented in the medical record by the 15th birthday."

C. Description of the Data

A baseline report was submitted in October of 2005 in which CRSA stated that a lack of documentation in sample member's medical records "led to an inability to calculate the percentage of youth with documented transition plans." AHCCCS did not accept this report and required additional baseline analysis.

In the revised baseline report CRSA acknowledges that the percentage of children in the sample with a documented transition plan is zero (0%). As a result of this, CRSA initiated several activities directed at improving the documentation of transition plans in member medical records. A remeasurement occurred during CYE 2007.

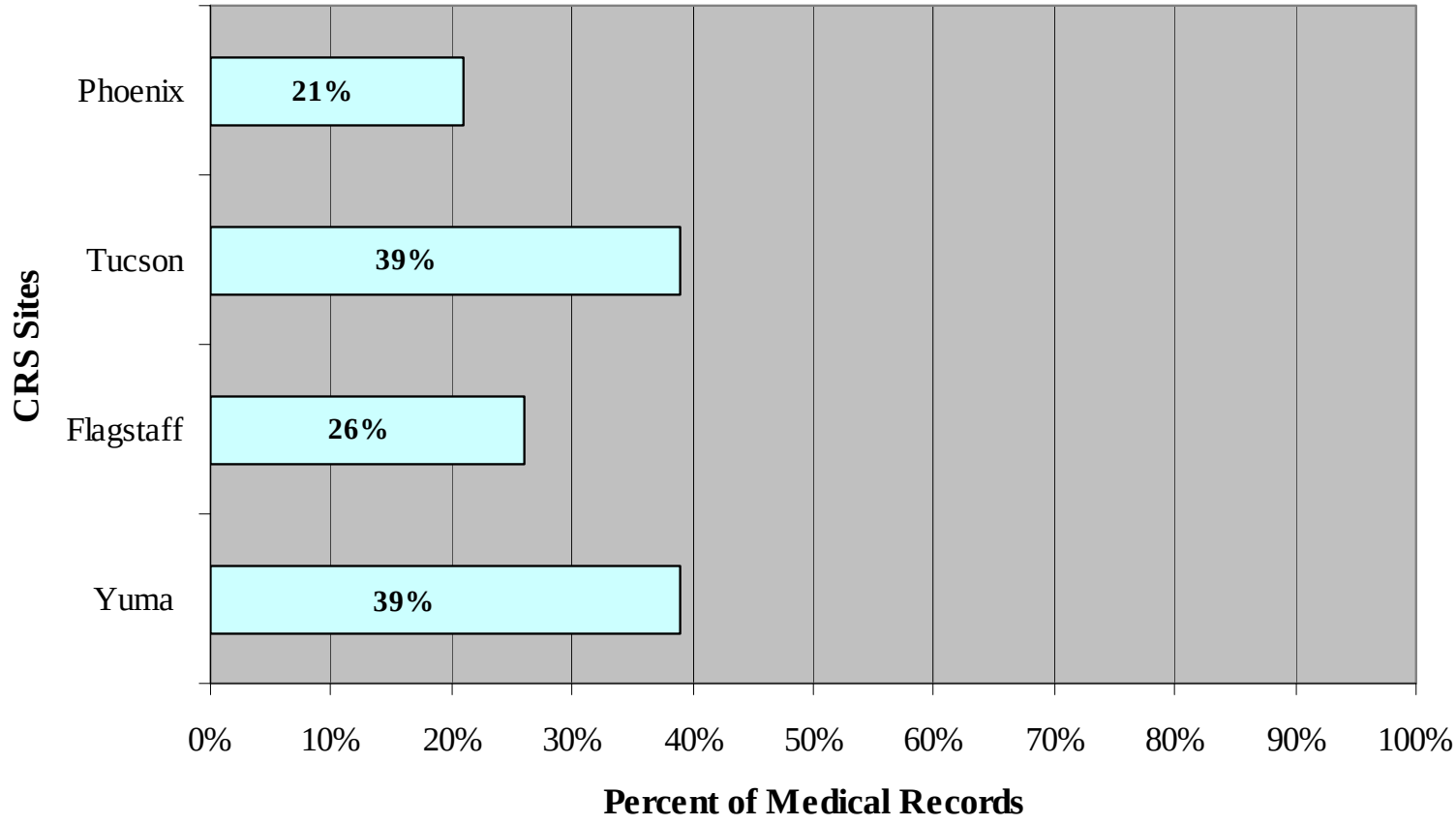
The first remeasurement conducted by CRSA reported that the proportion of AHCCCS eligible CRS members who turned 15 during the measurement period who had a transition plan initiated and documented by their 15th birthday was 29%. Rates varied by regional Contractor with Tucson and Yuma having 39% of medical records containing documentation of transition planning by the 15th birthday and Flagstaff and Phoenix at 26% and 21%. Table 6 and Chart 4 summarize the data reported by CRSA to date.

Table 6
AHCCCS Performance Improvement Project Reporting Format

Indicator Description #1: The proportion of AHCCCS-eligible CRS members who turned 15 during the measurement period who had a transition plan initiated and documented by their 15th birthday.

Measurement	Measurement Period	Numerator	Denominator	Rate (%)	Relative % Change	Statistical Significance	Indicator Goal
Baseline	7/1/2003 - 6/30/2004	0	347	0%	N/A	N/A	80%
Remeasurement 1	7/1/2006 - 6/30/2007	106	369	29%	N/A	<.05	80%

Chart 4: Percentage of Medical Records Containing Documentation of Transition Discussion Prior to the 15th Birthday by CRS Site



An analysis of these results by CRSA in its annual report to AHCCCS is very complete and thoughtful as is the barrier analysis and corrective action plan. Activities to improve performance were conducted from August 2005 to March 2007, and appear to have had a significant, positive effect on results. Further improvement is anticipated for the next measurement period.

D. Independent Data Validation

As part of the review of this PIP, QQ conducted a data validation exercise. The purpose of the data validation was to measure data agreement between the ADHS, CRS, and QQ sampled data on the measure "The percent of enrolled members with a documents transition plan initiated by their 15th birthdays."

QQ conducted a simple random sample of 30 cases with an over-sampling of 6 cases. A list of 36 prime identification numbers (and other case identifiers) was delivered to CRS as a request for charts so that QQ could conduct a review. One case was not returned. The data abstraction tool included in the contract was used to review the 35 medical records.

For the remeasurement period, the denominator of this measure would include CRS members born between July 1, 1991 and June 30, 1992, and who were continuously enrolled in CRS for 12 months prior to and including their 15th birthdays, and were concurrently enrolled in AHCCCS.

In the data provided to the statistician who performed this review, there were no variables provided to indicate continuous enrollment in CRS for 12 months, date of enrollment, date of withdrawal, or AHCCCS enrollment. The numerator criteria were not consistently recorded on the spreadsheet supplied to QQ. However, QQ did validate that all cases selected were for individuals within the proper age group to meet the denominator criteria. The results of QQ's review of the 35 CRS medical records according to the methodology specified in the CRSA contract are displayed in Table 7.

Table 7
Data Validation – Transition Plans by Regional Clinic

	CRS Regional Clinics				
Age at Initial Transition Plan	**Flagstaff**	**Phoenix**	**Tucson**	**Yuma**	**Total**
Over 15 Years Old	2	17	5	4	28 (80%)
Under 15 Years Old	0	2	4	1	7 (20%)
Total	2	19	9	5	35

While the results of the data validation conducted by QQ differ from those reported by CRSA (20% compared to 29%), the overall results and conclusions are the same. The number of children with a documented transition plan in the medical record initiated prior to their 15th birthday is below the desired goal of 80%. The activities outlined in the corrective action plan are appropriate as CRSA has already achieved significant improvement under the Transition PIP.

E. Assessment of Strengths and Weaknesses

The major strength of the proposal is the relevance and importance of the topic. This is clearly articulated in the background information section of the proposal. The document states that each year in the United States, nearly half-a-million children with special health care needs cross the threshold into adulthood. In the past those with the most severe disabilities died in childhood. Today more than 90% survive to adulthood. Thus, transition planning has become an important health care quality issue. Data collection procedures identify that a data abstraction tool will be used by CRSA staff to review transition plans from medical records of sampled members.

F. Conclusion

The percentage of AHCCCS eligible CRS children with a documented transition plan in the medical record prior to their 15th birthday is 20% to 29%, and is below the desired goal of 80%. However, significant improvement has been demonstrated since the baseline measurement of zero.

CRSA believes the improvement is the direct result of staff training that was provided to improve transition services and to emphasize the need to document that transition planning was discussed with the member and/or the family. CRSA required the regional Contractors to develop and implement policies and procedures to ensure that transition services are documented for all members prior to their 15th birthday.

The medical record review conducted by QQ confirmed that procedures are in place and in varying stages of completion. The remeasurement planned for this year should show continued improvement in the documentation of transition services for CRS members.

Non-Utilization among Children's Rehabilitative Services Members

A. Objectives

The purpose of this project is to identify AHCCCS children enrolled in the CRS program who have no service encounters in a one year period of time and to determine the reasons why. CRS chose this topic based on a historical review of their utilization data which showed that up to 45% of its enrolled population had no encounters in the system in a calendar year.

Non-utilization is of concern to CRSA because either the member no longer requires CRS services, or is not getting needed services and therefore has unmet needs. The issue of unmet need is not directly included in the project or addressed any further. This would have provided a clear link on how this project affects member health, functional status, or satisfaction.

B. Description of Data Collection Methodology

Two study questions are identified in this PIP proposal.

1. What is the proportion of all Title XIX/XXI eligible CRS members who were enrolled for at least 335 days during one year who had no encounters during that time period?
2. Does non-utilization vary by regional Contractor, demographics, or enrolling diagnosis?

The study indicator is the proportion of AHCCCS eligible CRS members with 335 or more days of enrollment during a calendar year. The study population is clearly defined. All members meeting the criteria will be included in the analysis.

Data collection procedures are clearly identified. The CRS administrative database is the source of data collection. An appropriate lag time for encounter reporting is included in the plan. There is no discussion of the limitations of using encounter data or of the possibility of services being provided at the health plan where members receive their primary care. An appropriate analysis plan was outlined and included in the proposal.

C. Project Summary

This project was approved by AHCCCS and a baseline report was submitted by CRS in November, 2006. The baseline report identified the proportion of AHCCCS eligible CRS members with 335 or more days of enrollment during one year who did not have any encounters during that year at 29.6%.

An analysis found that non-utilization increased with age and was highest among members 15 to 21 years of age. Regional variation and differences among diagnostic categories were found.

The analysis does not address differences in utilization based on age in the general population, nor is there any discussion of the available literature on utilization patterns by age. To date the discussion is focused on geographical and network issues that may be overshadowing other issues. The possibility that services may be provided by another payment source should be mentioned in the discussion.

Given that this is a baseline report, these issues may be addressed in future discussions of this project. CYE 2007 was the PIP's intervention year and as a result interventions are underway. The results of those interventions will be reviewed in the CYE 2008 EQR report.

[1]*Department of Health and Human Services, Centers for Medicare & Medicaid Services, Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPS): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR 400, 430, et al., Final Protocol, Version 1.0, February 11, 2003, p. 1.*

VIII. CONCLUSIONS AND RECOMMENDATIONS FOR CHILDREN'S REHABILITATIVE SERVICES ADMINISTRATION

CRS is a unique program that provides a limited scope of services to a special needs population. Due to the unique nature of this program the usual standards used to evaluate quality of care and service such as HEDIS® measures are not relevant to CRS.

In addition, all Medicaid eligible CRS children are concurrently enrolled with an AHCCCS Acute Care/ALTCS Contractor for their primary health care needs. This presents some challenges to measuring and evaluating the quality of care and/or service delivered by the CRS program. AHCCCS has had to find an alternative to the established standards for reviewing health plan performance and performance improvement projects for CRSA.

AHCCCS has established three performance measures tailored to the CRS program. The methodology to be used and minimum performance standards for the following measures were included in the CRS contract. The performance measures are as follows.

- Preliminary determination of medical eligibility
- Timeliness of initial evaluation
- First appointment with CRS specialty provider

This is the first year that data has been available to report on performance measures for CRSA. AHCCCS calculated rates on the performance measures indicated that CRSA is meeting the minimum standard for preliminary determination of eligibility and is below the minimum standard for timeliness of initial evaluation and first appointment with a CRS specialty provider. In response to these findings, CRSA has developed an extensive corrective action plan to improve performance on all three measures.

CRSA is currently working on two performance improvement projects which are Transition Services for Youth and Non-Utilization among Children's Rehabilitative Services Members. The Transition Services for Youth PIP is currently in year three. A baseline and one remeasurement have been completed.

The percentage of AHCCCS eligible CRS members with a documented transition plan in the medical record prior to their 15th birthday is 20% as calculated by QQ and 29% as calculated by CRS. While this is below the desired level, it is a significant improvement from the zero percent (0%) reported as the baseline measure and does represent a statistical improvement from the previous year.

CRSA has conducted a thorough analysis of the issues and barriers to providing transition services and is taking appropriate actions to improve performance in this area. The chart review conducted by QQ identified many activities and procedures in varying stages of completion directed at providing transition planning services for members prior to their 15th birthday. The remeasurement planned for this year should show continued improvement in the documentation of transition services for CRS members.

The Non-Utilization PIP is in year two, an intervention year. The baseline report identified the proportion of AHCCCS eligible CRS members with 335 or more days of enrollment during one year who did not have any encounters during the year at 29.6%. CRSA's analysis of these findings could be broadened to address other possible reasons for the lack of encounters.

Further work is needed to strengthen the significance of this performance improvement project. This may be accomplished in the coming year. Overall, CRSA has demonstrated significant progress in the reporting, documentation, and analysis of its PIPs this contract year.

Findings from the most recent OFR demonstrate that significant progress was made in CYE 2007. Full compliance has gone from 26% to 55.9% and noncompliance has dropped from 51% to 16.5% over the course of the contract year. The most significant improvement occurred in the areas of Grievance/Appeals, Quality Management, Recipient Services, and Medical Management.

Recommendations

CRSA needs to exercise greater care when measuring and reporting performance in reports required by AHCCCS. There were several instances where CRSA modified the methodology used to measure performance. This creates problems when data validation is attempted.

CRSA should ensure that its Medical Director is involved in quality functions including chairing the quality management, credentialing, and peer review committees. The Medical Director's involvement with these committees benefits their continuous quality improvement efforts.

CRSA needs to complete the Annual Administrative Reviews of the regional Contractors for all delegated functions. A written report that includes corrective actions and follow-up activities must be submitted to AHCCCS.

CRSA should follow the AHCCCS template in the Notice of Action User Guide. A process to monitor and review staff compliance with required procedures should also be implemented.

CRSA should evaluate its information systems to determine whether or not existing data applications are capable of supporting business needs and take appropriate action. Many areas of noncompliance are impacted by lack of to automated daily business functions. Meaningful reports in many areas needed to manage the business are not available. This negatively impacts almost all areas of compliance.

CRSA may benefit from simplifying the data used to report on PIPs. The data abstracted from the medical records exceeded what was required by the methodology outlined by the contract. While this is a common practice, CRSA should suppress these fields when transmitting the data to AHCCCS. The data validation process was complicated by the additional data.

APPENDIX

ADHS/CRSA
List of Documents Provided to HCE QualityQuest by AHCCCS for External Quality Review

1. EQRO Mapping Crosswalk
2. Operational and Financial Review for Contract Year (CYE) 2007
3. Member Handbook Approval Notice/Member Handbook Review Tool
4. Network Management and Development Plan Approval Notice/Network Management and Development Plan Review Tool
5. Delegated Agreement Checklist
6. CYE 07/08 AHCCCS/CRSA Contract
7. 2007 AHCCCS Quality Assessment and Performance Improvement Strategy, with Quarterly Update, and AHCCCS Medical Policy Manual Chapters 900 and 1000
8. CYE 2007 CRSA Contract: §D-13, Quality Management/Utilization Management and D-14, Performance Standards
9. CYE 2007 Quality Management (QM) Plan/Work Plan & Evaluation
10. CYE 2007 Utilization/Medical Management (U/MM) Plan/Work Plan & Evaluation
11. Contractor's Results for CYE 2007 OFR QM Standards
12. Contractor's Results for CYE 2007 OFR U/MM Standards
13. Contractor's Performance Improvement Project (PIP) Results
14. AHCCCS-reported Results of CYE 2007 Performance Measures
15. Contractor's Results for CYE 2007 OFR Encounter Standards
16. CRSA Notice to Cure Update

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